

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285096	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER Accura Healthcare of Franklin		STREET ADDRESS, CITY, STATE, ZIP CODE 1006 M Street Franklin, NE 68939	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Licensure Reference Number 175 NAC 12-006.11(D) Based on observation, record review, and interview the facility failed to ensure that food item temperatures were checked prior to food service to ensure that foods were served at a safe and appetizing temperature. This affected all facility residents. The facility census was 30. Findings are:Record review of the facility policy titled Food Temperatures dated 2021 revealed that the temperatures of all food items will be taken and properly recorded prior to service of each meal. All hot food items must be cooked to appropriate internal temperatures and held and served at a temperature of at least 135 degrees Fahrenheit (F). Hot foods may not fall below 135 F after cooking. Caution should be taken to avoid serving food and liquids at temperatures that are too hot to avoid the risk of burns. Temperatures should be taken periodically to assure that hot foods stay above 135 F and cold foods stay below 41 F during the holding and plating process and until food leaves the service area. Food preparation areas will hold foods at or below 41 F for cold foods and at or above 135 F for hot foods (to keep food out of the temperature danger zone- foods between 42 F and 134 F allow rapid bacteria growth and foodborne illness). Hold foods on a steam table for less than 4 hours (preferably less than 2 hours). Foods sent to the units for distribution will be transported and delivered to maintain temperatures at or below 41 F for cold foods and at or above 135 F for hot foods. Observation on 7/23/26 at 10:10 AM in the facility kitchen revealed that Dietary Cook-A (DC-A) placed raw pork chops in a steam pan. DC-A placed some pork chops on a baking sheet. DC-A prepared the cornbread stuffing and poured the stuffing over the pork chops in the steam pan. DC-A covered the pan with tin foil and placed it into the oven. DC-A placed the baking sheet of pork chops into the oven. Observation on 7/23/26 at 11:13 AM in the facility kitchen revealed that DC-A removed the baking sheet with pork chops from the oven. DC-A used a thermometer to check that the pork chops were cooked to the required final internal temperature. DC-A obtained a temperature of the pork chops of 176.7 F. DC-A used tongs to place 5 pork chops into a blender. DC-A ground the pork chops to a ground texture. DC-A placed the ground pork chop meat into a small steam pan and put the pan in the steam table. DC-A did not record the final cooking temperature. Observation on 7/23/26 at 11:35 AM in the facility kitchen revealed that DC-A removed the steam pan with pork chops and cornbread stuffing from the oven. DC-A used a thermometer to check that the pork chops were cooked to the required final internal temperature. DC-A obtained a temperature of the pork chops of 174.3 F. DC-A placed the steam pan of pork chops with cornbread stuffing into the steam table. DC-A did not record the final cooking temperature. Observation on 7/23/26 at 11:45 AM in the facility kitchen revealed that DC-A removed a pot of cauliflower from the stovetop. DC-A used a thermometer to check the final cooking temperature of the cauliflower. DC-A obtained a temperature of 185.0 F. DC-A used a slotted spoon to move the cauliflower from the pot and into a steam pan. DC-A placed the steam pan into the steam table. DC-A did not record the final cooking temperature. DC-A continued to prepare food items for meal service. The time was now 12:10 (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Licensure Reference Number 175 NAC 12-006.05(B) Based on interview and record reviews, the facility failed to inform the resident of services available in the facility and the charges for those services not covered by the facility's per dem rate. This affected 4 residents (Residents 1, 5, 36, and 37) of 4 residents sampled. The facility census was 30. Findings are: A record reviews of an Entrance Conference Worksheet provided to the facility on 7/22/2026 revealed a list of residents who were discharged from a Medicare covered Part A stay with benefit days remaining in the past 6 months. The worksheet revealed Resident 1, Resident 5, Resident 36, and Resident 37 were among those discharged from a Medicare covered Part A stay. A.A record review of a form titled, Therapy Discharge Notification dated 5/12/26 revealed Resident 1 to be discharged from Medicare A services and, can pick up Medicare B to continue activity tolerance. A record review of a form titled, Skilled Nursing Facility (SNF) Beneficiary Notification Review for Residents who Received Medicare Part A Services for Resident 1 revealed Medicare Part A services started on 3/4/26 and the last covered day for Part A services was list as 5/16/26. The form revealed Resident 1 discharged from services because the resident had a plateau in progress. The form further revealed that the facility provided a SNF Advance Beneficiary Notice of Non-coverage (ABN) to the resident or the resident's representative. The form further revealed that the facility provided a Notice of Medicare Non-coverage (NOMNOC) to the resident or the resident's representative. A record review of a form titled, Notice of Medicare Non-coverage dated 5/13/26 revealed Resident 1's representative signed the form for the resident over the phone. A record review of a form titled, Advance Beneficiary Notice of Non-coverage (ABN) dated 5/13/26 revealed Resident 1's representative signed the form over the phone. The form revealed if Medicare doesn't pay for D. below, you may have to pay. The line item was left blank. The form further stated, Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for D. below. The line item was left blank. The form further details: Read this notice, so you can make an informed decision about your care. Ask us any questions that you may have after you finish reading. Choose an option below about whether to receive the D. listed above, Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this. Area listed above found to be blank. Options; Check only one box. We cannot choose a box for you. Option 1 revealed, I want the D. listed above, left blank. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that is Medicare doesn't pay, I am responsible for left blank payment, but can appeal to Medicare by following the direction on the MSN (unknown acronym). If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles. Option 2 revealed, I want D. listed above left blank, but do not bill Medicare. You may ask to be paid now as I am reS06EibEtoFFayment. I cannot appeal if Medicare is not billed. Option 3 revealed, I don't want the D. listed above left blank. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay. The form revealed, beginning on left blank, you may have to pay out of pocket for this care if you do not have other insurance that may cover these costs. The form revealed, care left blank, estimated costs, left blank, reason Medicare may not pay, left blank. The form further states: singing below means that you've received and understand this notice. You'll also get a copy for your records. The signature of patient or authorized representative, left blank, dated, left blank. B.A record review of a form titled, Therapy Discharge Notification dated 7/8/26 revealed Resident 5 to be discharged from Medicare A services and, can pick up Medicare B for continued (continued on next page)		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	services. A record review of a form titled, Notice of Medicare Non-coverage dated 7/13/26 revealed Resident 5 signed the form in person. A record review of a form titled, Advance Beneficiary Notice of Non-coverage (ABN) dated 7/13/26 revealed Resident 5 signed the form in person. The form revealed if Medicare doesn't pay for D. left blank below, you may have to pay. The line item was left blank. The form further stated, Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for D. below. The line item was left blank. The form further details:Read this notice, so you can make an informed decision about your care.Ask us any questions that you may have after you finish reading.Choose an option below about whether to receive the D. listed above, Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this. Area listed above found to be blank.Options; Check only one box. We cannot choose a box for you.Option 1 revealed, I want the D. listed above, left blank. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that is Medicare doesn't pay, I am responsible for left blank payment, but can appeal to Medicare by following the direction on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.Option 1 was found to be underlinedOption 2 revealed, I want D. listed above left blank, but do not bill Medicare. You may ask to be paid now as I am reS06EibEtoFFayment. I cannot appeal if Medicare is not billed.Option 3 revealed, I don't want the D. listed above left blank. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.The form revealed, beginning on left blank, you may have to pay out of pocket for this care if you do not have other insurance that may cover these costs.The form revealed, care left blank, estimated costs, left blank, reason Medicare may not pay, left blank.The form further states: singing below means that you've received and understand this notice. You'll also get a copy for your records.The signature of patient or authorized representative, left blank, dated, left blank. C.A record review of a form titled, Notice of Medicare Non-coverage dated 4/29/26 revealed Resident 36 signed the form in person. A record review of a form titled, Advance Beneficiary Notice of Non-coverage (ABN) dated 4/29/26 revealed Resident 36 signed the form in person. The form revealed if Medicare doesn't pay for D. left blank below, you may have to pay. The line item was left blank. The form further stated, Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for D. below. The line item was left blank. The form further details:Read this notice, so you can make an informed decision about your care.Ask us any questions that you may have after you finish reading.Choose an option below about whether to receive the D. listed above, Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this. Area listed above found to be blank.Options; Check only one box. We cannot choose a box for you.Option 1 revealed, I want the D. listed above, left blank. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that is Medicare doesn't pay, I am responsible for left blank payment, but can appeal to Medicare by following the direction on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.Option 2 revealed, I want D. listed above left blank, but do not bill Medicare. You may ask to be paid now as I am reS06EibEtoFFayment. I cannot appeal if Medicare is not billed.Option 3 revealed, I don't want the D. listed above left blank. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.Option 3 was found to be underlined.The form was signed by Resident 36 and dated on 4/27/26.The form revealed, beginning on left blank, you may have to pay (continued on next page)		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	out of pocket for this care if you do not have other insurance that may cover these costs. The form revealed, care left blank, estimated costs, left blank, reason Medicare may not pay, left blank. The form further states: singing below means that you've received and understand this notice. You'll also get a copy for your records. The signature of patient or authorized representative, left blank, dated, left blank. D. A record review of a form titled, Therapy Discharge Notification dated 7/6/26 revealed Resident 37 to be discharged from Medicare A services and met all goals, to discharge home with spouse and home care. A record review of a form titled, Notice of Medicare Non-coverage dated 7/6/26 revealed Resident 37's representative signed the form in person. A record review of a form titled, Advance Beneficiary Notice of Non-coverage (ABN) dated 7/6/26 revealed Resident 37's representative signed the form in person. The form revealed if Medicare doesn't pay for D. left blank below, you may have to pay. The line item was left blank. The form further stated, Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for D. below. The line item was left blank. The form further details: Read this notice, so you can make an informed decision about your care. Ask us any questions that you may have after you finish reading. Choose an option below about whether to receive the D. listed above, Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this. Area listed above found to be blank. Options; Check only one box. We cannot choose a box for you. Option 1 revealed, I want the D. listed above, left blank. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that is Medicare doesn't pay, I am responsible for left blank payment, but can appeal to Medicare by following the direction on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles. Option 2 revealed, I want D. listed above left blank, but do not bill Medicare. You may ask to be paid now as I am reS06EibEtoFFayment. I cannot appeal if Medicare is not billed. Option 3 revealed, I don't want the D. listed above left blank. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay. Option 3 was found to be underlined. The form was signed by Resident 37's representative and dated on 7/6/26. The form revealed, beginning on left blank, you may have to pay out of pocket for this care if you do not have other insurance that may cover these costs. The form revealed, care left blank, estimated costs, left blank, reason Medicare may not pay, left blank. The form further states: singing below means that you've received and understand this notice. You'll also get a copy for your records. The signature of patient or authorized representative, left blank, dated, left blank. An interview on 7/23/26 at 3:00 PM with Social Service Director (SSD) revealed they were unaware of the details they needed to add on the SNF ABN forms detailing per diem costs. SSD revealed they were not familiar with the process and how to obtain the information missing from the SNF ABN forms necessary to make informed decisions for residents and resident representatives. SSD confirmed this information had not been provided to Residents 1, 5, 36, and 37 as required.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Licensure Reference Number 175 NAC 12-006.09(I) Based on observation, record review, and interview the facility failed to implement interventions to prevent falls for 1 of 1 residents reviewed (Resident 23). The facility census was 30. Findings are: Record review of the facility policy titled Risk Management dated 9/27/24 revealed that all accidents/incidents involving residents will be reported, investigated, and reviewed through the facility's Quality Assurance Process Improvement (QAPI) process to ensure that residents receive the highest quality of care. The nurse identifying an incident will be responsible for completing the incident report. The paragraph titled Completion of Incident Reports revealed that the immediate action taken, assessment at the time of the incident, and interventions initiated (care plan intervention) section of the incident report are completed. Ensure that the intervention is appropriate and care planned. Review all residents who have had 2 or more incidents in 30 days for trending and the need for further interventions to prevent accidents. Record review of the Minimum Data Set (MDS, a mandatory comprehensive assessment tool used for care planning) for Resident 23 dated 6/10/26 revealed that Resident 23 admitted into the facility on 6/23/25. The assessment revealed that Resident 23 was dependent on staff to put on and take off socks, shoes, and other footwear. Resident 23 was independent with lying to sitting on the side of the bed. Resident 23 was to have supervision for standing from a sitting position and toilet transfers. The assessment revealed that Resident 23 had 2 falls since the prior MDS assessment was completed. Record review of the facility Incidents By Incident Type log dated 7/22/26 revealed that Resident 23 had falls on: -2/15/26 at 5:50 PM (unwitnessed fall)-2/23/26 at 11:45 AM (unwitnessed fall)-3/20/26 at 12:00 AM (unwitnessed fall)-5/23/26 at 3:37 PM (witnessed fall) Record review of the current Care Plan for Resident 23 dated 7/22/26 revealed that Resident 23 was at risk for falls due to unsteady gait, poor balance, and psychotropic medication use (any medication that affects behavior, mood, thoughts, or perception). Interventions to be in place to prevent falls included ensuring that Resident 23's phone was within reach 2/15/26; Dycem on the side of the bed on floor to prevent fall due to resident refusing to wear socks 2/23/26; non-slip footwear when sitting up on the side of the bed to hold Resident 23 from sliding off the edge of the bed and to have the walker within reach 3/20/26; assure the resident had appropriate footwear on when up 2/5/26; encourage to use call light to alert staff of needing assistance 6/17/26; encourage to use grab bars in the bathroom to steady self with toileting 6/17/26; Physical and Occupational therapy referral as needed 2/5/26; and use walker with ambulation (walking) 6/17/26. Record review of the Progress Note dated 2/15/26 at 5:50 PM for Resident 23 revealed that the facility received a call from the resident's child stating that Resident 23 had fallen and needed help. Staff found Resident 23 laying on the floor with the resident's head close to the night stand by the bathroom door. The Progress Note revealed that Resident 23 used a walker for walking and usually called for staff assistance when needing the bathroom. The Progress Note revealed that Resident 23 did not use the call light. Record review of the current Care Plan for Resident 23 dated 7/22/26 revealed that the interventions for Resident 23 included a fall on 2/15/26. The Care Plan revealed that Resident 23 lost their balance while trying to get to a phone call. The new intervention for the fall was to ensure that the resident's phone was within reach. Record review of the Progress Note dated 2/23/26 at 11:45 AM for Resident 23 revealed that a nurse aide helped Resident 23 into the restroom and instructed Resident 23 to use the call light when finished. The nurse aide returned to the resident's room and observed Resident 23 lying on their back in front of the recliner. Resident 23 told the nurse aide that they got impatient and started to walk back to bed and (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	their legs gave out. Resident 23 complained of right leg and hip pain. Record review of the current Care Plan for Resident 23 dated 7/22/26 revealed that the intervention for the fall on 2/23/26 was to place Dycem (a medical-grade non-slip material used to prevent residents from slipping) on the floor on the side of the bed to prevent falls as Resident 23 refused to wear socks. Record review of the Progress Note dated 3/20/26 at 2:22 AM for Resident 23 revealed that staff went into the room of Resident 23 to answer the call light and found Resident 23 on the floor next to the bed. Resident 23 was barefoot. Resident 23 stated that their feet slipped. Record review of the current Care Plan for Resident 23 dated 7/22/26 revealed that the fall on 3/20/26 causal factor was that Resident 23 slid off the side of the bed. (Dycem was to have been in place on the floor on the side of the bed to prevent the resident from slipping per the intervention listed on the care plan for the fall on 2/23/26). The intervention for the fall on 3/20/26 was for non-slip footwear when sitting up on the side of the bed and to have the resident's walker within reach. Record review of the Progress Note dated 5/23/26 at 3:37 PM for Resident 23 revealed that Resident 21 was at the door of Resident 23's room talking to Resident 23. Resident 21 yelled to the nurse that Resident 23 fell. Resident 23 stated that they slipped off the bed. Resident 23 was sitting on the floor beside the bed. (Dycem was to have been in place on the floor on the side of the bed to prevent the resident from slipping per the intervention listed on the care plan for the fall on 2/23/26). Record review of the current Care Plan for Resident 23 dated 7/22/26 revealed that it contained no new intervention to prevent falls following the fall that occurred on 5/23/26. Record review of the Progress Note dated 5/25/26 at 11:53 AM for Resident 23 revealed that the note was for fall follow-up. The Progress Note revealed that Resident 23 was encouraged to have non-slip footwear upon sitting on the side of the bed and that Dycem was ordered. Record review of the Progress Note dated 5/27/26 at 10:19 AM for Resident 23 revealed that the risk management team met to review the witnessed fall by Resident 23 on 5/23/26. Resident 23 slid off the bed because the resident does not want to wear footwear. Staff will now encourage Resident 23 to wear gripper socks during transfers and when the resident's feet are on the floor. Dycem is available to utilize if Resident 23 is not compliant with footwear. Observation on 7/23/26 at 9:35 AM in the room of Resident 23 revealed that Resident 23 sat on the edge of the bed and was barefoot. No dycem was on the floor on the side of the bed to prevent Resident 23 from slipping. Interview on 7/27/26 at 9:26 AM with Medication Aide-D (MA-D) revealed that Resident 23 was independent when they first came to the facility. Resident 23 had movements of their shoulders and arms and was encouraged to call for assistance with transfers. MA-D revealed that Resident 23 wore slip on sandals with a strap on the back when going out of the facility. MA-D revealed that Resident 23 did not like shoes and would not use gripper socks. Observation on 7/27/26 at 9:29 AM in the room of Resident 23 revealed that there was no Dycem on the floor at bedside or anywhere in the room. Observation on 7/27/26 at 2:49 PM in the room of Resident 23 revealed that a pair of black sandals sat underneath the left side of the bed. Resident 23 sat on the bed with bare feet and there was no Dycem in place on the floor on the side of the bed. Interview on 7/27/26 at 2:49 PM with Resident 23 revealed that the resident wore the pair of sandals under the bed when going out to appointments. Resident 23 confirmed that there had not been any Dycem placed on the floor next to the bed to prevent slipping. Resident 23 revealed that there was Dycem under the wheelchair cushion in their wheelchair seat to keep the cushion from sliding. Interview on 7/28/26 at 9:31 AM with MA-E revealed that MA-E did not think there were any fall prevention interventions for Resident 23. MA-E revealed that Resident 23 was independent with walking to the bathroom and did not wear footwear. MA-E revealed that Resident 23 did not want their feet to get hot and was usually barefoot. MA-E revealed that they would walk with Resident 23 to the bathroom when getting Resident 23 up in the (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	morning. MA-E revealed that the resident had gripper socks but they were not worn when walking to the bathroom. Interview on 7/28/26 at 10:25 AM with Licensed Practical Nurse-G (LPN-G) revealed that the nurse completes a risk management report in the resident electronic health record after a resident fall. LPN-G revealed that the risk management section had a link to the Care Plan and the nurse puts the new intervention into the Care Plan. LPN-G revealed that new fall prevention interventions were put on the Critical Charting list that was then reviewed with nurse aides and medication aides during start of shift report to make them aware of new fall interventions that were to be in place. Interview on 7/28/26 at 10:46 AM with MA-F revealed that fall prevention for Resident 23 was to try and get the resident to wear gripper socks. MA-F confirmed that no Dycem was on the floor as a fall intervention for Resident 23. Interview on 7/28/26 at 10:46 AM with LPN-G revealed that LPN-G told MA-F that Dycem was supposed to be a fall prevention intervention for Resident 23. Interview on 7/28/23 at 10:53 AM with MA-F revealed that MA-F did not have access to the Care Plan and did not know that an intervention of Dycem on the floor on the bedside was to be in place for Resident 23. Interview on 7/28/26 at 10:53 AM with LPN-G confirmed that the fall prevention intervention for Resident 23 for Dycem on the floor at the side of the bed was not in place as care planned to prevent falls. Interview on 7/28/26 at 1:47 PM with the Facility Administrator (FA) confirmed that the facility was required to determine the cause of each resident fall and implement an intervention to prevent additional falls. The FA confirmed that the fall intervention was to be on the care plan and implemented.		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(H)(vi)(3)(c) Based on record review, observation, and interview, the facility failed to ensure that nursing staff were competent in the administration of Intravenous (IV) medications when a using Peripherally Inserted Central Catheter (PICC, a long, thin, flexible tube inserted into a vein in the upper arm and threaded up to a large vein near the heart) line for 1 (Resident 38) of 1 sampled resident. The facility census was 30. Findings are: Record review of an untitled facility policy dated 7/31/23 revealed on page 1 that the purpose of the policy was for the initiation by the Licensed Practical Nurse (LPN) for intravenous (IV, directly into the blood stream via a vein) catheter administration of intravenous medications or fluids as prescribed by a physician. (Peripheral and PICC line catheters. LPNs must have successfully completed IV education and competency with a Registered Nurse at the facility prior to providing any peripheral IV services and on an annual basis. On page 6, the first paragraph revealed that prior to medication administration in an intermittent access device, the IV will be checked for patency (flow without blockage) by observing for blood return and flushed using a 10 milliliter syringe. PICC lines must be flushed with at least 10 ml (milliliters) of normal saline or as directed by a physician. Record review of the Lippincott Nursing Procedures manual to review with Standards of Practice while using a peripheral intravenous central catheter (PICC) line, the manual revealed that with each use of the PICC line, the nurse must confirm a venous blood return and catheter patency before initiating any infusion. For flushing and locking, document the site's appearance as well as the date, time, and type and amount of flush solution used. Document patency, absence of signs and symptoms of complications, lack of resistance when flushing, and presence of blood return on aspiration if the PICC functions correctly. Document signs and symptoms of complications or if the PICC fails to function appropriately, steps taken to troubleshoot the problem, the date and time the practitioner was notified (if applicable), prescribed interventions, and the response to those interventions. Document whether the patient experienced pain or discomfort during flushing. [NAME] & [NAME]. 2023. Lippincott Nursing Procedures - 9th Ed. Philadelphia. [NAME] & [NAME]. ISBN 978-1-9751-7858-1. eISBN 978-1-9751-7860-4. STAT!Ref Online Electronic Medical Library. https://online.statref.com/document/BQ69WV5ALrIh8OGpR3v_gD. 7/29/2026 8:08:07 AM CDT (UTC -05:00). Record review of Resident 38's electronic Medication Administration Record, while observing LPN-G prepare the medication administration, revealed Resident 38 had an order for an antibiotic medication: Meropenem 500 milligrams (mg) in sodium chloride 50 milliliters (ml) intravenously to be given over a period of 30 minutes. Observation on 07/27/2026 at 11:17 AM of LPN-G as supplies for the IV medication (med) were gathered, an area on an over the bed table was cleaned and supplies laid out for the medication administration by LPN-G. LPN-G took an alcohol swab and cleansed the area on Resident 38's PICC line, flushed the PICC line with 10 ml of saline solution using the 10 ml syringe from the supply bag, mixed the medication with the IV fluids, attached the IV tubing to the medication, filled the tubing with the medication to ensure there was no air in the IV tubing, then attached the tubing to Resident 38. LPN-G then set the IV-delivery system to the correct settings so that the IV fluids would infuse (go into the blood stream) over the required 30 minutes, gathered the remaining supplies, checked on the resident, left the room, and charted the medication in the electronic medication administration record. Interview 07/27/2026 at 12:20 PM with the Director of Nursing revealed that the facility followed the policies and procedures as noted by the standards of care and as is written in their policies which were not very (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	explicit. Interview on 07/27/2026 at 12:45 PM with the DON revealed that there were no competencies completed when LPN-G was hired and that there had not been a competency skills day completed for staff competencies yet this year. Interview on 07/27/2026 at 1:10 PM with LPN-G who confirmed that when the PICC line was accessed for the medication administration that LPN-G did not check for blood return prior to initiating (starting) the PICC line. It was confirmed that this was the first time that LPN-G had given the IV antibiotic to this resident since Resident 38 was readmitted to the facility following a hospital stay. LPN-G confirmed that the infusion pump was also different than that which was usually sent to the facility and they had not used a pump like that for a while. Interview with MDS Coordinator (MDSC) on 07/27/2026 at 1:15 PM revealed that the facility got orders for iv infusions for residents so rarely that it would be best to have a review each time they received orders for an IV medication for a resident and to do the review with the LPNs. MDSC confirmed that getting blood return was important in the administration of IV meds when using a PICC line to ensure correct placement of the PICC line and to rule out any other issues that may have occurred since the last use. MDSC confirmed that usually the facility had a different type of delivery system that what was provided for Resident 38. Interview with the DON on 07/27/2026 at 1:30 PM confirmed that it was a standard of care to try to get blood return when using a PICC line. The DON also confirmed that there was no competency or skills test completed when LPN-G was hired or in the files of LPN-G.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Licensure Reference Number 175 NAC 12-006.18(B) Based on record reviews, observations and interviews, the facility failed to use appropriate infection control practices when providing respiratory care services for 1 resident (Resident 12) of 1 sampled. The facility census was 30. Findings are: A record review of a policy titled, Respiratory Equipment Cleaning Procedure dated 11/13/24 revealed; oxygen condensers: Oxygen (O2) tubing, nasal canula/mask will be changed weekly. O2 tubing will, also, be changed when tubing (nasal prong area) is noted lying on the floor. The condenser will be wiped down with disinfectant as needed and after the resident no longer needs the condenser. Pre-filled humidifier bottle needs to be replaced weekly and as needed (dated and initialed). Refillable humidifier receptacle needs to be cleaned weekly. O2 concentrator filter-needs to be cleaned weekly. Remove and rinse with warm running water. Dry between clean towels or shake excess water off and allow to air-dry-do not replace while still wet. A record review of Resident 12's Order Summary dated 7/27/26 revealed and order: 1-4 liters (L) of oxygen via nasal canula (a light, flexible plastic device with two short prongs used to deliver extra oxygen from a tank or wall source directly into the nostril) to keep oxygen saturations (sats, measuring how much oxygen is in your blood) above 88% three times a day; order date 6/8/26; start date 6/8/26. An observation on 7/22/26 at 1:12 PM in Resident 12's room revealed an O2 concentrator with a black mesh bag hanging from the machine. Inside of the black mesh bag contained O2 tubing with a 1-inch piece of tape folded on the tubing written 6/8. An observation on 7/23/26 at 2:15 PM in Resident 12's room revealed an O2 concentrator with a black mesh bag hanging from the machine. Inside of the black mesh bag contained O2 tubing with a 1-inch piece of tape folded on the tubing written 6/8. An observation on 7/27/26 at 11:15 AM in Resident 12's room revealed an O2 concentrator with a black mesh bag hanging from the machine. Inside of the black mesh bag contained O2 tubing with a 1-inch piece of tape folded on the tubing written 6/8. An interview on 7/27/26 at 1:29 PM with the Director of Nursing (DON) reveals that all residents who are using oxygen condensers and concentrators should have an order to change the filter and nasal canula and/or mask and clean the machine weekly. The DON agreed that the order was not listed on the order summary for Resident 12 and was probably the reason why the concentrator was not cleaned and why the nasal canula was not changed weekly per policy.		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.18(A) Based on record review and interview, the facility failed to provide an influenza and pneumococcal immunization when offered. This affected 1 resident (Resident 4) of the 3 residents sampled. The facility census was 30. Findings are: A record review of a policy titled, Influenza Vaccine dated 11/13/24 revealed, all residents of our facility will be questioned on admission, in regards to if they have had the influenza vaccine for the present flu season. Each year during the months of October-March, each resident/family will be educated and offered the flu vaccine injection. Procedure, during admission assessment, each resident/family will be questioned regarding if the resident has had a current flu vaccine injection. Vaccination in the facility will be contraindicated if: They have been previously immunized this flu season. If they have ever had a serious allergic reaction to eggs. If they have ever had a serious allergic reaction to the flu vaccine. History of Guillain-Barre Syndrome (discuss with physician). Physician writes order to not give vaccine. Resident/family member refuses vaccine. Acute febrile illness. Condition is terminal. A record review of a policy titled, Pneumococcal Vaccinations dated 11/13/24 revealed, all residents will be provided with the opportunity and encouragement to receive pneumococcal vaccinations. On admission each resident will be questioned regarding history of receiving the pneumococcal vaccine (offer year round). Each resident will be educated and offered the pneumococcal vaccine if they have never had the vaccine. The Director of Nursing (DON) will be responsible for following up with the physician's office when questions arise as to whether resident has had a vaccine in the past. Procedure, during admission assessment, each resident/family will be questioned regarding pneumococcal status. Vaccination is contraindicated for those resident who: Have been previously immunized after age [AGE]. If it has been less than 5 years since previous vaccine. If resident has a reported allergy to the vaccine. Physician orders to not give the vaccine. The resident or family member refuses. Febrile illness. Condition is terminal. A record review of a Clinical Census sheet dated 7/28/26 for Resident 4 revealed an admission date of 10/29/25. A record review of a form titled, Acknowledgement of Vaccine Information Statement (VIS) and Vaccination Consent for Resident 4 signed on 2/25/26. The form revealed Resident 4 check marked they received a copy of the most up to date VIS and education for the influenza vaccine. The form further revealed Resident 4 would like to have the influenza vaccine given. The vaccine will be administered in the influenza season. The form also revealed Resident 4 has received a copy of the most up to date VIS and education for the Pneumococcal vaccine. The form further revealed Resident 4 would like to have the pneumococcal vaccine given. A record review for the influenza and pneumococcal vaccines provided to Resident 4 revealed no evidence of either vaccine being provided. An interview with the Infection Preventionist (IP) on 7/28/26 at 10:15 AM confirmed Resident 4 had not received their vaccinations and the IP was unsure why this had not occurred.		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Licensure Reference Number 175 NAC 12-006.18(A) Based on record review and interview, the facility failed to provide a COVID-19 immunization after 1 (Resident 4) of 3 sampled residents had consented to receive it. The facility census was 30. Findings are: A record review of a facility policy titled, COVID-19 Vaccination dated 11/13/24 revealed, all residents will be provided with the opportunity and encouragement to receive COVID-19 vaccinations. On admission each resident will be questioned regarding history of receiving the COVID 19 vaccine. Each resident will be educated and offered the COVID-19 vaccine if they have never had the vaccine. The DON will be responsible for following up with the physician's office when questions arise as to whether resident has had a vaccine in the past. Procedure, during admission assessment, each resident/family will be questioned regarding if the resident has had a current COVID-19 vaccine injection. Vaccination in the facility will be contraindicated if: If they are currently up to date with all recommended COVID-19 vaccinations. If they ever had a serious allergic reaction of any severity to a previous dose. Physician writes order to not give vaccine. Resident/family member refuses vaccine. Acute febrile illness. Condition is terminal. A record review of a Clinical Census sheet dated 7/28/26 for Resident 4 revealed an admission date of 10/29/25. A record review of a form titled, Acknowledgement of Vaccine Information Statement (VIS) and Vaccination Consent for Resident 4 signed on 2/25/26. The form revealed Resident 4 check marked they received a copy of the most up to date VIS and education for COVID-19 vaccine. The form also revealed Resident 4 would like to have the COVID-19 vaccine given to them. A record review for the COVID-19 vaccine provided to Resident 4 revealed none was provided. An interview with the Infection Preventionist (IP) on 7/28/26 at 10:15 AM confirmed Resident 4 had not received the COVID-19 vaccine and the IP was unsure why this had not occurred.		